HAWTHORN SCHOOL DISTRICT #73
Vernon Hills, IL 60061

SEIZURE MANAGEMENT PLAN

(To be completed by parent - please use black ink)

School Year _____to _____

Student Photo

Student _____ Grade _____ Teacher _____

Name/Daytime phone: Mother _____/_____Father_____/_____

Physician _____Address _____Phone _____

TYPE(S) OF SEIZURE: _____

DESCRIPTION OF TYPICAL SEIZURE:

- ❒ Body involvement: _____
- ❒ Average duration:_____
- ❒ Frequency (daily/weekly/other): _____
- ❒ Usual times of day: _____
- ❒ Behavior/warning prior to seizure: _____
- ❒ Student response to seizure:_____

CARE NEEDED DURING SEIZURE: _____

_____

CARE NEEDED AFTER SEIZURE:

- ❒ Rest for approximately _____ minutes in nurse's office
- ❒ Other _____

DAILY MEDICATION

MEDICATION	DOSE/ROUTE	TIME	POSSIBLE SIDE EFFECT

(OVER)

PHYSICAL EDUCATION/TEAM SPORTS/RECESS:

❒ Full participation, no limitations

❒ Participation with the following modifications _____

_____

EMERGENCY INTERVENTION:

❒ If seizure lasts longer than _____ minutes, then _____

❒ If _____ or more seizures occur in a row, then _____

❒ If seizure occurs on the bus, then _____

❒ Other _____

INSTRUCTIONS:

❒ Seizure Observation Record (see attached sample) to be completed by staff during school and shared with parents on a _____ (weekly/monthly/other) interval. Best method of exchange of information:

_____.

❒ If school is unable to reach parents in an emergency, permission is granted to contact physician, listed above.

Additional comments: _____

_____

_____

❒ I/we agree to release this information to the following staff, as appropriate, with the expectation that confidentiality will be respected at all times:

❒ Teachers

❒ Substitute teacher(s)

❒ Recess staff

❒ Other _____

❒ After school caregivers/coaches

❒ Bus personnel

❒ Cafeteria/kitchen personnel

_____ _____

Parent Signature Date

File: Temporary Student Health Record
SNC: Seizure Management Plan